

# MHS *Optimization Plan*



*Interim Report*

Deputy Executive Director, TMA  
Deputy Surgeon General, U. S. Army  
Deputy Surgeon General, U. S. Navy  
Deputy Surgeon General, U. S. Air Force

February 1999



# **MHS Optimization Plan**

## **February 1999 Interim Report**

### **Table of Contents**

Executive Summary .....	1
Introduction .....	3
Overview .....	4
The End State Vision .....	10
Triservice Readiness Model .....	11
Readiness Costing Model.....	14
Triservice Enrollment Model .....	16
Population Health Improvement .....	19
Triservice Workload Model .....	22
Triservice Resourcing Model .....	24
Triservice Metrics .....	26
“Most Effective Organization” .....	27
Timeline.....	29

# MHS Optimization Plan

## February 1999 Interim Report

### Executive Summary

#### **MHS VISION**

**The MHS is responsive and accountable to DOD, line leadership, and our beneficiaries to ensure force health protection and optimize the health of MHS beneficiaries by providing best value health services using best clinical and business practices.**

To support development of a comprehensive and integrated health services delivery system, the Principal Deputy Assistant Secretary of Defense (Health Affairs), the Director TRICARE Management Activity in conjunction with the Deputy Surgeons General created the MHS Reengineering Coordination Team (RTC). In the overall ASD(HA) directed effort to create a benchmark health services delivery system and an executable funding program, twenty nine initiatives were identified in the overarching strategy for implementing the high performance military health system. Facility optimization was identified as Initiative #4 and quickly became the central focus of MHS reengineering. Herein is the RCT's multi-dimensional approach to System/Facility Optimization.

***Our focus will shift from providing primarily interventional services to better serving our beneficiaries by preventing injuries and illness, improving the health of the entire population while reducing demand for the more costly and less effective tertiary treatment services.***

Full implementation of this comprehensive optimization plan will result in a high quality, cost effective health service delivery system that will be understood by all its users and withstand the scrutiny of critics and cost analysts. We will be the benchmark health service delivery system in peace and war and the health services delivery option of choice for our beneficiaries. We will be a best-buy for both our beneficiaries and the Nation. Most importantly, our focus will shift from providing primarily interventional services to better serving our beneficiaries by preventing injuries and illness, improving the health of the entire population while reducing the demand for the much more costly and less effective tertiary treatment services. We anticipate significant cost avoidance as the need for interventional services diminishes.

MHS optimization has these underlying tenets:

- ① Effective use of readiness-required personnel and equipment to support the peacetime health service delivery mission.
- ① Equitably align resources to provide as much health service delivery as possible in the most cost effective manner – within the MTF.
- ① Use the best, evidence-based clinical practices and a population health approach to ensure consistently superior quality of services.

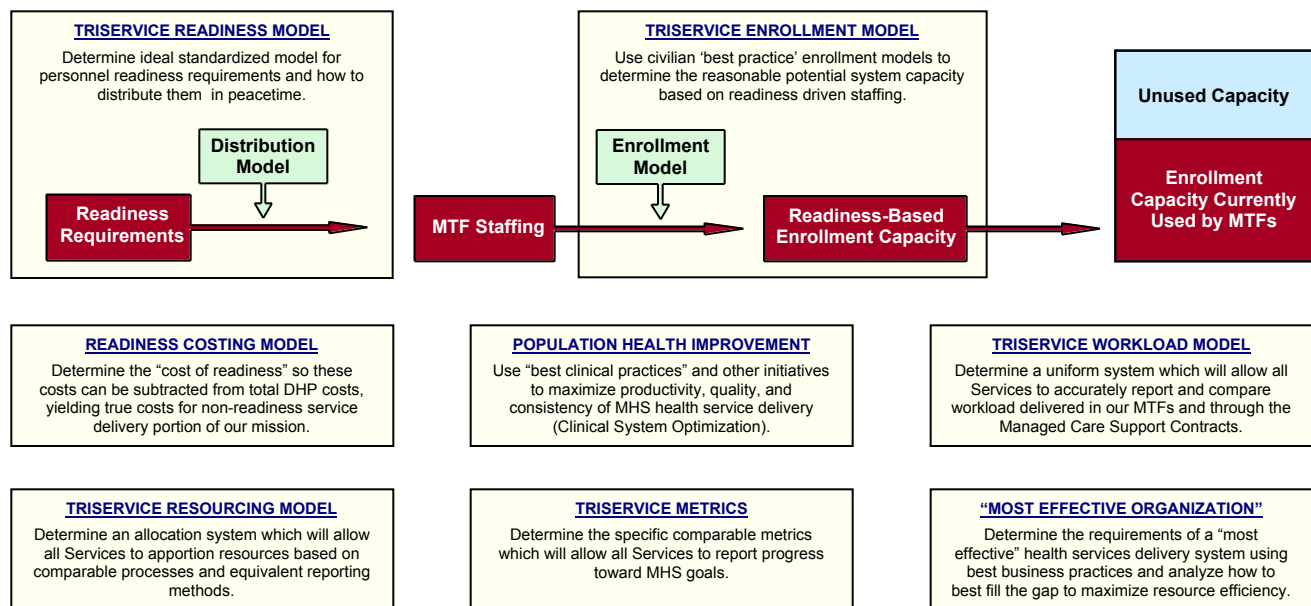
Our strategy includes development of these eight component tasks, coordinated and integrated into the overall plan:

- ① Determine the ideal standardized model for personnel readiness requirements and how to distribute them in peacetime.
- ① Determine the "cost of readiness" so they can be subtracted from the total DHP costs, yielding the true costs for the non-readiness service delivery portion of our mission.
- ① Use civilian "best practice" enrollment models to determine the reasonable potential system capacity based on readiness-driven staffing.

- ⌚ Use "best clinical practices" and other initiatives to focus on population health and maximize quality, productivity, and consistency of MHS health services service delivery (clinical system optimization).
- ⌚ Determine a uniform system which allows Services to accurately report and compare workload delivered in our MTFs and through Managed Care Support contracts.
- ⌚ Determine an allocation system which allows all Services to apportion resources based on comparable processes and equivalent reporting methods.
- ⌚ Determine comparable metrics which allow the Services to report progress toward goals.
- ⌚ Determine the requirements of a "most effective" health services delivery system using benchmarked business practices and analyze how to best augment our readiness-based staffing to maximize resource efficiency.

While several of the MHS initiatives can produce significant cost avoidance in the short term, MHS reengineering and resource realignment can only be accomplished in the POM cycle. Therefore, major components of this plan will be incorporated in the FY2002-FY2007 POM submission.

Charters, plans of action, and milestones have been developed and deployed. Many of the workgroups already existed without the integrated and coordinated focus and tri-Service commitment with active senior leadership involvement. Timelines vary – some are nearly complete while others will require several months to finish. The RCT provides weekly interim reports to the Deputy TMA/Surgeons General. The objective is to define and program for the most effective organization, facility by facility until the MHS is populated with the best solution in both business and clinical practices. The attachments and appendixes reflect our progress and roadmap to affordability and accountability for the MHS. The eight critical components are illustrated in the figure below.



Implementation of these plans will lead to profound improvement in our service delivery methods as well as our ability to support staffing and other resource allocations. Many of the other MHS reengineering initiatives are critical inputs into our complete system. Policies on pharmacy redesign, role and number of lead agents, redesigned managed care support contracts, and the need for an integrated clinical information system are critically important to completing the optimization. Using the "most effective organization" approach to ensure adequate staffing and resourcing, we anticipate being able to serve more of our beneficiaries in the direct care system (our MTFs) where quality services are delivered for costs less than our civilian counterparts. We will clearly demonstrate the cost effectiveness of our system.

# MHS Optimization Plan

## February 1999 Interim Report

### Introduction

In November, 1998, the Surgeons General, Deputy Surgeons General, and Health Affairs/TRICARE Management Activity executive staff chartered a triservice team of senior officers to conduct research, oversee working groups, integrate initiatives, and recommend strategies and operational plans to achieve the MHS vision through system/facility optimization.

#### ***MHS REENGINEERING COORDINATION TEAM CHARTER***

***The MHS' success depends on innovations and enterprise-wide reengineering. The Reengineering Coordination Team is chartered by and reports to MHS leadership to conduct research, coordinate working groups, integrate initiatives, and recommend strategies and operational plans to achieve the MHS vision.***

#### **Team Members**

---

Captain Donald Arthur, MC, USN	Navy representative
Colonel Frank Berlingis, MSC, USA	Army representative
Colonel Thomas Broyles, MSC, USA	Army representative
Captain William (Mitch) Heroman, MC, USN	TRICARE Management Activity representative
Colonel Michael Parkinson, USAF, MC	Air Force representative

Colonel Dan Blum, MSC, USA is an *ad hoc* consultant from the Health Affairs staff in his role as overall coordinator of the twenty nine reengineering initiatives. One of our Team's tasks is to ensure the applicable initiatives are developed in concert with the reengineering plans.

#### **Purpose**

---

The purpose of this reengineering effort is twofold. First to realign the staffing and resource allocation of the Direct Care System with the mission of the MHS. Second, to optimize the effectiveness and efficiency of the resultant staffing and resources to deliver the most health services to the maximum number of beneficiaries.

#### **Vision and Expectations**

---

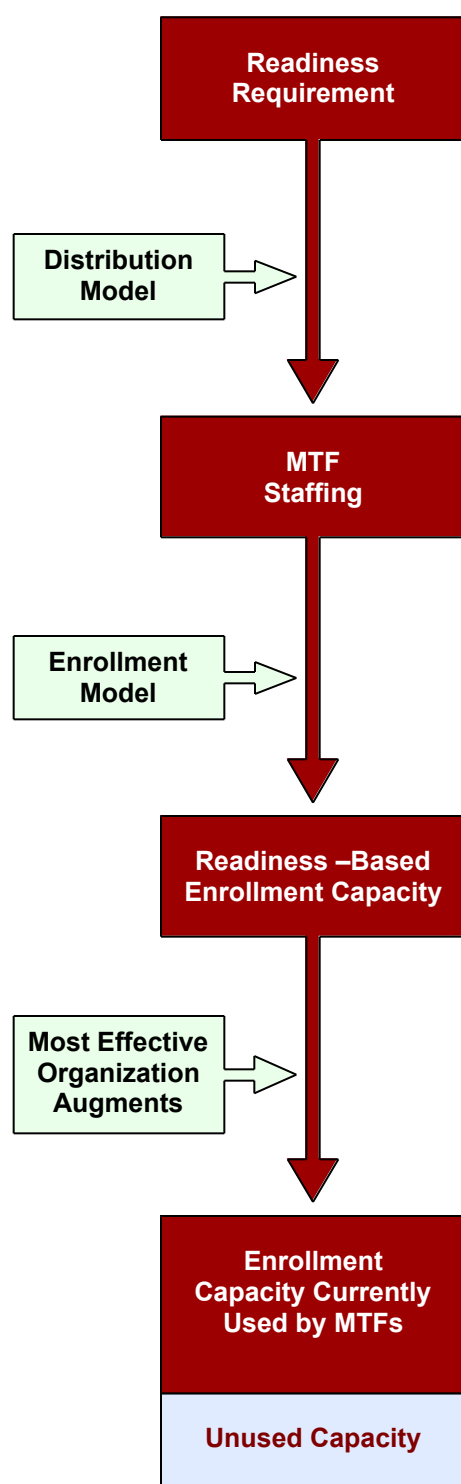
The MHS is responsive and accountable to DOD, line leadership, and our beneficiaries to ensure force health protection and optimize the health of MHS beneficiaries by providing best value health services using best clinical and business practices.

Implementation of these plans will lead to profound improvements in our service delivery methods as well as our ability to support our staffing and other resource allocations. Using the 'most effective organization' approach to ensure adequate staffing, we will be able to serve more of our beneficiaries in the direct care system (our MTFs) where quality services are delivered for costs less than our civilian counterparts. And we'll be able to clearly demonstrate the cost effectiveness of our system.

# MHS Optimization Plan

## February 1999 Interim Report

### Overview



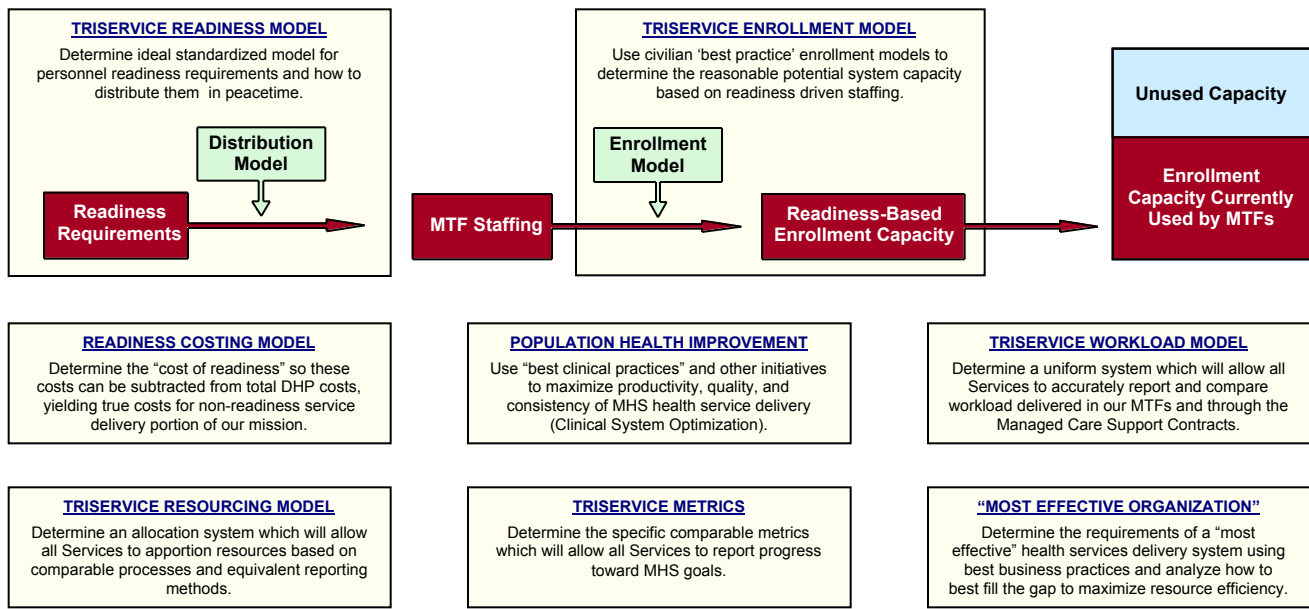
Our reengineering vision begins with the readiness mission. We must be sized to meet the mission mandated for us by Congress, as interpreted by our Services. It is their mission that we support and our staffing levels must be in direct response to the line's needs for medical support for their mission elements. The sizing model agreed upon by all Services is called the **DOD Sizing Model** and all Services have agreed to tie their baseline staffing levels to this readiness model.

The next step is to distribute the readiness-based staffing throughout the Services' MTFs and other commands. Each Service determines how its staff will be distributed based on a variety of factors. Chief among these factors are their readiness and garrison operational support missions. Other factors such as catchment area beneficiary population and community availability of services are also considered.

From the Services' staffing models, the enrollment model is formulated and used to predict the level of health services which should be accomplished by an MTF based on its readiness-based staffing level. This links the health service level of effort to our readiness requirements. The enrollment model is based on civilian 'best practice' norms, adjusted for military and Service-unique requirements. To be truly efficient, we recognize we must also augment staff with personnel who are not part of a wartime mission in the numbers required to run an effective health service delivery system (discussed fully in the following sections).

After MTF enrollment capacities are established, they can be compared with the current levels of effort to provide services to enrollees and determine what potential exists to recapture TRICARE network workload. Our MTF capacity must provide all health services required for the readiness mission. Above that level, many system-reliant beneficiaries can be enrolled – hopefully including some who are currently receiving services in the network. In other words, **there could be increased potential for recapturing TRICARE contractor workload.**

We parsed the above described process into the eight component tasks as illustrated on the following page. The Reengineering Coordination Team will concurrently coordinate each group's efforts to ensure continuity.



## Triservice Readiness Model

*Determine the ideal standardized model for personnel readiness requirements and how to distribute them in peacetime.*

As described above, the three Services have agreed on a single readiness-based staffing model. This model will determine the minimal Service staffing level based purely on the wartime mission specified by line requirements. Service-specific peacetime staff distribution models will help each Service distribute these staff to MTFs and other facilities based on local and Service requirements.

**Base Service staffing on the readiness mission, augmented to ensure a cost efficient health service delivery system which most effectively employs our personnel and other resources.**

**Distribution Model:** The readiness-based staffing will be distributed by the Services based on their models and priorities which account for readiness and operational support requirements, catchment area demographics and health service demands, and availability of civilian health services.

## Readiness Costing Model

*Determine the "cost of readiness" so these costs can be subtracted from the total DHP costs, yielding the true costs for the non-readiness service delivery portion of our mission.*

Critical to demonstrating MHS cost effectiveness is an ability to clearly and accurately articulate the cost of maintaining Service readiness, including all health services not performed for other than active duty personnel. Our total 'costs' are slightly higher than some competing programs (like the Federal Employees' Health Benefits Plan). However, we have not subtracted the costs of those services for which our competitors are never responsible - such as deployments, personnel readiness, readiness training, and so many more that come easily to mind. Included in these readiness requirements are costs which are not normally considered such as the cost of performing limited duty boards for which there is no civilian counterpart. These are all costs of readiness. When subtracted from our total health service delivery costs, the remainder reflects the proportion of our true costs which can be compared with those of civilian benchmarks.



---

## **Triservice Enrollment Model**

---

*Use civilian “best practice” enrollment models to determine the reasonable potential system capacity based on readiness driven staffing.*

***Optimize enrollment using best clinical and business practices from benchmark organizations and maximize the proportion of beneficiary services performed by the direct care system.***

An enrollment model must be based on best clinical and business practices used in successful benchmark health service delivery systems. From this starting point, adjustments are made for our military-specific personnel and training requirements to determine reasonable potential system capacities. Inherent in defining enrollment capacities is our need to provide the right support for our providers, also discussed below under the topic of “Most Effective Organization.”

## **Population Health Improvement**

---

*Use “best clinical practices” and other initiatives to maximize productivity, quality, and consistency of MHS health service delivery  
(Clinical System Optimization).*

***Shift the fundamental philosophy of the MHS from INTERVENTION to PREVENTION, improving the health of our population so services are not required – but when they are, they’ll be of the highest quality and immediately accessible.***

The charter of this existing initiative (formerly MHS Initiative #4: Facility Optimization) is to use “best clinical practices” and other processes to maximize productivity, quality, and consistency of MHS health service delivery. Optimizing population health is the primary goal of the MHS, moving from interventional services to primary prevention of illnesses and injuries. The MHS Reengineering Coordination Team will ensure the goals and products of this initiative fold seamlessly into the overall MHS reengineering plan.

## **Triservice Workload Model**

---

*Determine a uniform system which will allow all Services to accurately report and compare workload delivered in our MTFs and through the Managed Care Support Contracts.*

A common workload accounting system is critical to our ability to draw interservice comparisons and, in the process, identify and promote “best” and most cost efficient practices. A ‘visit’ in each Service should have precisely the same meaning, but there are currently widely disparate definitions. We would like to determine a uniform system which will allow all Services to accurately report and compare workload delivered in our MTFs and through the Managed Care Support Contracts.

## **Triservice Resourcing Model**

---

*Determine an allocation system which will allow all Services to apportion resources based on comparable processes and equivalent reporting methods.*

Linked with and of equal importance to workload accounting is a single allocation system which will allow Services to apportion resources based on comparable processes and equivalent reporting methods. This is not a single accounting system but a model which will allow full asset visibility, comparisons within individual MTFs, and interservice comparisons. Our medical accounting systems are integrally linked to our Services’ overarching accounting methods - each tailored to Service-



---

specific needs and quite different. For example, when calculating the costs involved in delivering services at an MTF, the Navy factors all base support costs because they are part of their operating budget. In the Air Force, base operations are supported by line activities and not apportioned as part of the MTFs' costs. Standardized resourcing policies and practices must be institutionalized for both readiness and population-based requirements to allow inter-Service comparisons and adoption of uniform business plans.

## **Triservice Metrics**

---

*Determine the specific comparable metrics which will allow all Services to report progress toward MHS goals.*

A set of MHS metrics is key to our ability to measure performance, motivate and drive change, and communicate to our stakeholders. Metrics will be linked to critical components of the MHS vision and be available for review and comparison at all levels of the enterprise. The Triservice Metrics Workgroup will investigate which specific comparable metrics will allow all Services to report progress toward MHS goals. Where applicable, MHS metrics will mirror civilian performance and quality measures.

## **“Most Effective Organization”**

---

*Determine the requirements of a “most effective” health services delivery system using best business practices and analyze how to best fill the gap to maximize resource efficiency.*

Once we determine Service-specific readiness staffing requirements, we must determine and quantify what additional resources are needed for the MHS to be a “most effective” health services delivery system. We will analyze how to best fill the gap between the “most effective” model and the readiness-based staffing model. Examples may include such specialties as pathology, nutrition management, and comptrollers. There certainly will not be sufficient readiness-justified staffing of these and other personnel to allow our health service delivery system to function optimally. After we identify these gaps, we must perform make/buy decisions (business case analyses) and find ways to assemble the staffing necessary to allow our system to be fiscally efficient. This is one of the most critical elements of the reengineering plan - without which we will not be able to provide the most services for our beneficiaries while being good resource stewards.

***Employ our scarce Service resources in the most effective manner, using ‘best clinical and business practices’ gleaned from the most successful civilian benchmark organizations.***

The “most effective organization” will facilitate smooth business relationships between MTF commanders, Lead Agents, and Managed Care Support Contractors.

Key to building a “most effective organization” and accomplishing other goals is our ability to track individual and population-based clinical data, system and individual performance, and other quality indicators. Data integrity and a computerized patient record are essential for progress. We must have the capability to gather meaningful data to be converted to information on which we can make business decisions.

We anticipate continual improvement and refinement of our policies, practices, and processes and incorporation of evolving technology will be required for the MHS to become a “most effective” organization.

---

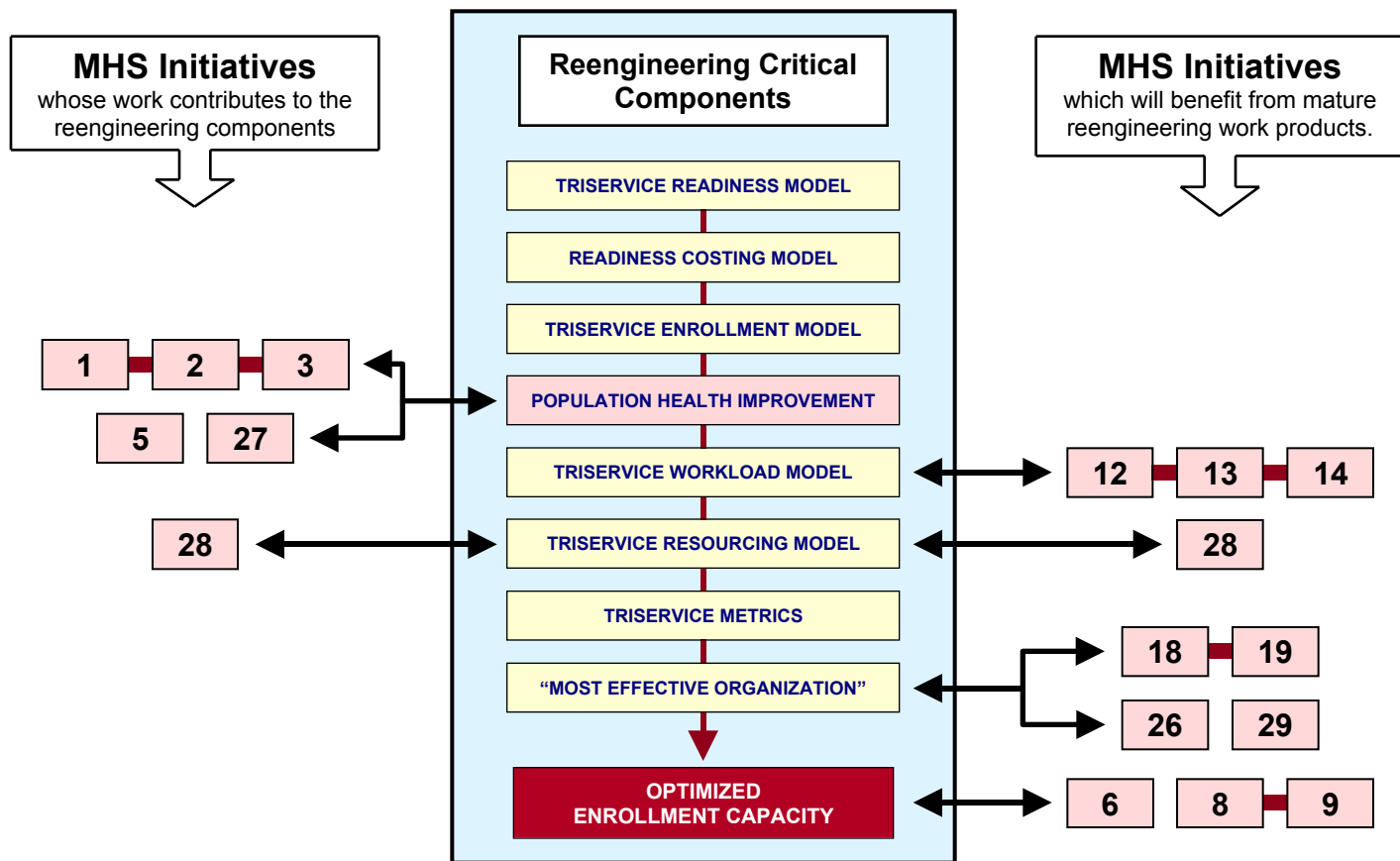
We have developed charters, plans of action, and milestones for the components outlined above. The timeline for their products will be varied - some have been nearly completely developed already by existing working groups.

Implementation of these plans will lead to profound improvements in our service delivery methods as well as our ability to support our staffing and other resource allocations. Using the ‘most effective organization’ approach to ensure adequate staffing, we will be able to serve more of our beneficiaries in the direct care system (our MTFs) where quality services are delivered for costs less than our civilian counterparts. And we’ll be able to clearly demonstrate the cost effectiveness of our system.

Although none of these ideas is completely new, what is new and exciting is the triservice collaboration and agreement of all three Services to the difficult elements of standardization and comparability. The most significant progress thus far has been agreement among the three Services for a single triservice readiness-based staffing model, single triservice workload accounting system, and a single triservice resourcing model. These are phenomenal milestones toward a triservice system which ensures uniform staffing and resource allocation.

**Interrelationship with other MHS Initiatives.** As the following figures illustrate, many of the other MHS initiatives are applicable to the efforts of this reengineering plan. Chief among these are initiatives 1/2/3, 5, 27, and 28. Other initiatives may benefit from the work performed by the RCT and its chartered component teams, particularly 6, 8/9, 12/13/14, 18/19, 26, 28, and 29. For example, creation of an effective enrollment capacity model may assist others who are considering how to best analyze the catchment area demographics and other factors when formulating the best approach to Medical Center resizing and consolidation. We will review the efforts of other groups to ensure our composite efforts are aimed at the same MHS end state vision.

MHS INITIATIVES	
1 Pharmacy NMOP	16 USAF MILPERS reductions
2 Federal schedule pricing	17 GME consolidation
3 Pharmacy automation	18 Regionalize purchasing
4 MHS facility optimization	19 Regionalize medical repair
5 MHS Information technology	20 Medical technician training
6 Lead Agent consolidation	21 Facility life cycle management
7 Triservice preventive medicine	22 Beneficiary support
8 MEDCEN resizing	23 TRICARE benefit policy
9 MEDCEN consolidation	24 TRICARE staff training
10 Aeromedical Evacuation	25 Medical technology acquisition
11 AFIP reengineering	26 Outsourcing opportunities
12 Reduce MCS administrative costs	27 Reengineer prevention
13 MCS 3.0 refinements	28 Improve resourcing
14 MCS payment changes	29 Improve MHS management
15 Reduce military construction	
	Initiatives combined



# MHS Optimization Plan

## February 1999 Interim Report

### The End State Vision

#### **The MHS Mission**

---

The MHS is responsive and accountable to DOD, line leadership, and our beneficiaries to ensure force health protection and optimize the health of MHS beneficiaries by providing best value health services using best clinical and business practices.

#### **Service Delivery System End State Vision**

---

Our end state vision the reengineered MHS will include the following system attributes:

**Military mission:** The MHS must be responsive to readiness missions, meet Service readiness requirements, and support Service personnel readiness requirements. Staffing must follow readiness missions – “staffing to requirements.” The MHS will implement robust injury/illness prevention programs.

**The Customer:** Customer service will be paramount. Our beneficiaries must have easy access to services, information, and assistance. Our system will be responsive to beneficiaries’ needs, including benefit and claims assistance. Enrollment and reenrollment will be easy. The benefit will be uniform and transportable.

**Quality:** Our health services delivery system will receive JCAHO and NCQA accreditations. We will use an effective Utilization Management program which will include components of provider and beneficiary education, health promotion/prevention, primary care management, demand management, referral management, case management, clinical pathways/guidelines, disease management, discharge planning, and utilization review. “Best” clinical practice guidelines will be universally adopted to reduce clinical variance and improve quality. Clinicians will use easily accessible evidence-based clinical decision-making tools and receive timely professional improvement training.

**Health Care Administration:** Our system will be optimized to gain maximal efficiency and cost effectiveness, using a responsive, standardized IM/IT infrastructure. Costs of goods and services will be readily ascertainable. Costs of our readiness mission will be separable. Decisions will be based on a standardized business case analysis tool which will facilitate uniform resource allocation.

**Information management:** A coordinated information management system will allow robust and responsive data analysis and tracking functions. The patient record will be computerized! The combination of data tracking programs and the computerized patient record will allow providers to receive timely feedback on costs and clinical outcomes for individuals and populations.

**Population health focus:** The health of the population will be paramount – we will move from focusing primarily on interventional services to better serving our beneficiaries by preventing illnesses and injuries through their full life cycle. Prevention and screening programs will be fully deployed and measurable. Beneficiaries will be full partners in all their health decisions.

**Performance incentives for MTF COs and providers:** Incentives and feedback will be provided to our staff, based on well-established performance metrics, directly linked to the MHS mission.

# MHS Optimization Plan

## February 1999 Interim Report

### Triservice Readiness Staffing Model

#### CHARTER

The Force Allocation Working Group began developing the Force Allocation Method in July 1995 to determine the best way to allocate military medical requirements determined by the DOD Sizing Model. The original charter to *"Identify policy and procedures which influence the allocation of medical forces and develop and apply models which will guide the appropriate allocation of medical forces in the future to fulfill the MHS mission"* was refined to include the following:

- ⌚ Identify common doctrine, policies, rules, studies, laws, principles and assumptions.
- ⌚ Formulate common guidelines consistent with existing doctrine and policy.
- ⌚ Provide a framework within which senior leadership can communicate, evaluate, and decide on appropriate force allocation.
- ⌚ Identify opportunities and methods for MHS to privatize capabilities while sustaining readiness and optimizing cost, quality and access.

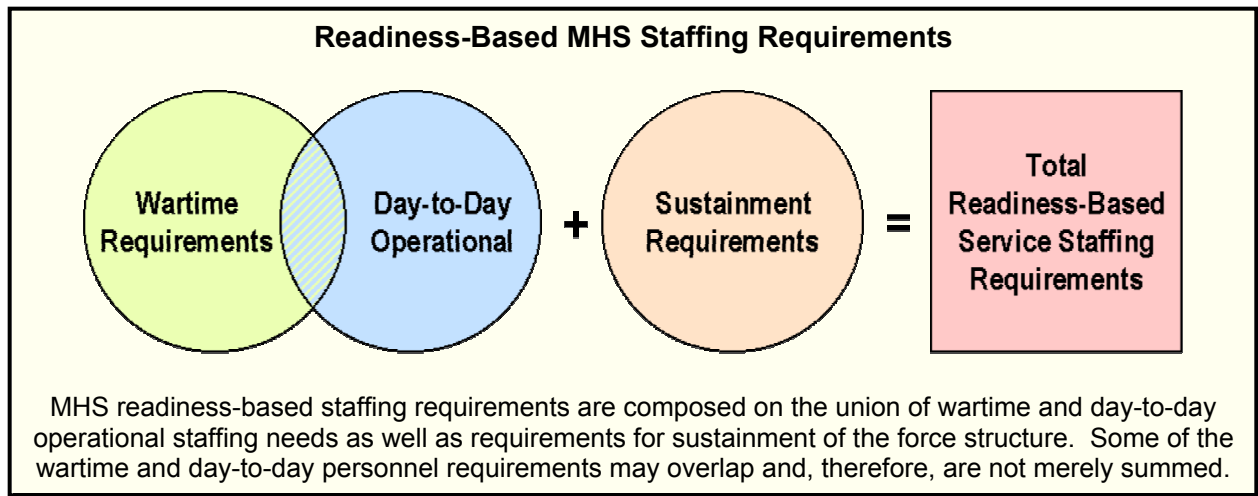
To determine the required number of military medical personnel required on active duty, several interrelated subsets of personnel must be carefully quantified. These include fully trained personnel on operational platforms in peacetime, on operational platforms in wartime, and stationed overseas and other remote locations. Given a well-defined set of fully trained personnel, a fully trained population must be added to support normal tour rotation (a "rotation base"). Finally, to support the sum of these requirements, a population in training must be calculated, based on training program lengths and experientially based attrition rates.

Determining the necessary size of the military medical departments has been the subject of many studies, the most prominent of which have been what have come to be known as the Section 733 Study and the Section 733 Study Update (from Section 733 of the 1994 Defense Authorization Act). Under the direction of the Under Secretary of Defense (Comptroller), Director for Program Analysis and Evaluation (PA&E), the first study primarily addressed the wartime requirement for active duty military physicians but did not address other operational requirements or circumstances (e.g. OCONUS or remote CONUS) requiring a uniformed provider. The follow-on assessment (Section 733 Update) was commissioned to gauge the effects on physician end-strength requirements of changes in U.S. force levels and planning scenarios that had occurred since the original Section 733 study was conducted. Although the second study remains unpublished, its development resulted in a general consensus among the three military departments regarding a sizing method – then called the Defense Medical Sizing Model. To simplify and expedite these studies, only military physician requirements were examined. (To answer Congressional inquiries about the size of the DOD medical establishment the active duty physician end strength requirement was thought to represent a reasonable surrogate for total medical end strength requirements.)

The Defense Health Program supports two missions that are symbiotic in that medical manpower and infrastructure required and financed for the readiness mission are available to cost-effectively deliver

a substantial portion of the health benefit entitlement that would otherwise be met through the private sector; delivery of health services in support of the health benefit mission in turn serves as a means of maintaining medical skills necessary to support operational forces in wartime.

The wartime requirement for active duty military medical personnel is a straightforward sum of all such personnel assigned to operational platforms or units during combat, according to individual Service doctrine concerning use of active duty versus Reserve component members. The wartime requirement does not include overseas or remote personnel, a rotation base, or training pipeline; it is merely a snapshot of peak operational medical end strength requirements at various points along the war plans timeline.



The MHS maintains more medical end strength in the active component than wartime missions require for several reasons. One of the most important is the need to staff medical facilities that serve military populations posted in locations with very limited or no access to civilian health care facilities. Examples include operating locations overseas and some extremely remote sites in the continental United States (CONUS). This “peacetime operational requirement,” added to the wartime estimate, yields a sum that generates two additional sustainment requirements. The first is a population with which operationally-based medical personnel will normally rotate (known as the “rotation base”). The second is a training pipeline to feed the sum of all these requirements (wartime, peacetime operational, and rotation base).

Military manpower allocation decisions must account for both of these missions, by building a core readiness capacity that best supports the operational mission according to each Services’ doctrine, and then optimizing health services delivery to the local catchment area by distributing additional civilian and military manpower above the readiness requirement in support of this readiness core. Health services required in the local catchment area beyond the capacity of the military medical treatment facility is then purchased in the private sector.

The financial benefits of organizing an efficient, cost-effective health services system around a readiness core are twofold. First, manpower and infrastructure needed for the readiness mission are fully financed as a direct cost of maintaining a ready medical force, and the associated costs are readily identified as a “fixed cost” of readiness at a definable capacity. The medical services provided by this “fixed cost” readiness core is therefore a direct benefit of readiness training, financed as a cost of readiness. Second, services provided in a military medical treatment facility (MTF) beyond that

---

required for readiness training may then be compared on the margin to the cost of services purchased at full cost in the private sector.

In its simplest form, the question is: “What is the minimum active duty medical personnel requirement?” In the Section 733 studies and other analyses, this involves specification of both the wartime and the supplemental requirement explained above, the latter most often referred to as the Sustainment and Training (S&T) base.

In assessing total requirements, active-duty medical personnel may be organized into six categories:

- ⌚ Those required as primary and augmenting medical staff of operational units.
- ⌚ Those committed to providing services for the beneficiary population overseas (OCONUS).
- ⌚ Those committed to providing services for the beneficiary population in medically isolated areas of the continental United States (CONUS), where competent civilian caregivers are impossible to attract regardless of economic considerations.
- ⌚ Those needed to meet mobilization requirements beyond primary platform manning and categories already mentioned, including casualty replacements, certain research and development (R&D) personnel, and residual personnel needed to offset the small percentage of the active-duty medical force that would temporarily be unavailable for deployment for medical or administrative reasons.
- ⌚ Those required beyond mobilization to serve as a peacetime “rotation base” for like personnel assigned to OCONUS, CONUS, or operational billets.
- ⌚ A sufficient number of medical personnel in education and training pipelines to maintain a fully trained medical force that meets the above requirements.

These component parts, in sum, represent the minimum number of military medical personnel required on active duty. Determining active duty medical personnel requirements is based solely on operational requirements and those circumstances where competent civilian health services are unavailable to care for active duty military members and their families. It’s important to note there is no consideration of care requirements for other beneficiaries or cases in which active duty providers may be more cost-effective in providing the statutory health care benefit.

## **Services’ Readiness Staffing Distribution Models**

Based on the Service staffing levels determined by the DOD Sizing Model, each Service will craft its staffing distribution model. These plans will necessarily be different to fit the needs of each Services’ operational missions, treatment facility sizes and locations, and demographic demands of treatment facility catchment area populations.



# MHS Optimization Plan

## February 1999 Interim Report

### Readiness Costing Model

#### CHARTER

Develop a consistent method to determine the readiness costs embedded in the Military Health System (based on Service-specific force allocation and distribution models). Costs Identified will be subtracted from the Defense Health Program costs to yield the true costs for the non-readiness service delivery portion of the MHS mission.

The model will:

- ⌚ Identify both fully burdened and incremental costs (i.e., those costs above normal HMO type costs) associated with active duty care regardless of capitation category.
- ⌚ Identify all military unique functions – (i.e., physical examinations, diving medicine, physical readiness requirements, flight medicine, etc).
- ⌚ Identify direct readiness costs associated with forward deployed status – (i.e, overseas presence in the form of all MTFs in overseas locations - Capitation Category I).
- ⌚ Identify all costs related to military unique medical training.
- ⌚ Identify all costs associated with medical requirements unique to military – (i.e., Limited Duty, Physical Evaluation Boards, Fitness for Duty evaluations, Medical Holding Companies, etc).
- ⌚ Incorporate performance metrics to gauge planned versus actual resource consumption for readiness.
- ⌚ Ensure all components are comparable and uniform in definition and application except where it is inappropriate.

The Military Health System faces the unique challenge of jointly operating and funding both a high quality and cost effective peacetime health services system and simultaneously managing the only HMO that can deploy, go to war, and support the increasing demands of “operations other than war.” The costs as well as the challenges for operations such as humanitarian health services support missions to Africa, emergency medical evacuations from Guam and disaster relief in Honduras are typical of expanded global involvement of the MHS in peacetime operations. Maintaining medical readiness is an essential mission of the MHS. The cost of accomplishing medical readiness is often

***The Readiness Costing Model will determine the "cost of readiness" so these expenses can be identified and subtracted from the total DHP costs, yielding the true value for the non-readiness service delivery portion of our mission as well as identify the burdened costs necessary to support an active duty force.***

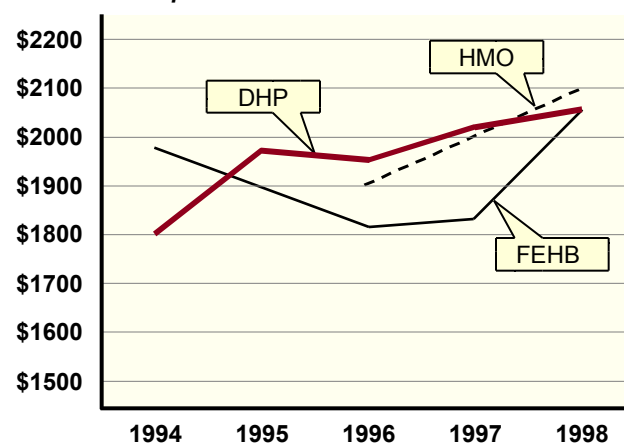
either buried or absorbed in our MTF operations and distorts civilian sector comparisons. More importantly, with medical readiness and Force Health Protection our primary missions for the MHS, resourcing peacetime health services cannot be permitted to erode essential and military unique

medical mission requirements. In a cost competitive environment it is more important than ever that the MHS be able to identify both its peacetime and readiness costs. Because there are options for delivering the peacetime health services benefit but no alternative for meeting the medical readiness mission, we must identify both the fully burdened MHS costs of supporting the active force and the incremental costs above those identified as required to support a typical civilian-like health services plan. The figure below illustrates a favorable comparison of actual per-member-per-month costs for the DHP, FEHBP, and a typical U.S. HMO. Accurate readiness costing will allow us to make direct comparisons of the isolated health service delivery costs, unencumbered by readiness mission elements.

The Readiness Costing Model will attempt to both discern and aggregate costs, both direct and indirect, in support of readiness. Unique costs in support of a deployable force might include additional immunizations, eye exams, force health protections requirements, medical exams for security/sensitive positions and medical boards, and other military personnel related health requirements. Additionally, clinical training for medical personnel (including infrastructure and travel) for both graduate medical/dental education and enlisted medical specialist training must be costed. With increasing deployments, the opportunity cost associated with shifting health service delivery to managed care support

contractors must also be identified when we deploy active duty staff and are simultaneously required to maintain the same level of access for our enrolled beneficiaries. Finally, with an increased emphasis on Total Force readiness, medical and dental support to the Reserve Components will become an increasingly larger proportion of our health services expenditures.

*Comparison of Per User Costs*



Source: Center for Naval Analysis study, 1998

The military personnel costs as well as infrastructure and direct health services expenditures for providing health services are captured in our Medical Expense and Performance Reporting System (MEPRS) with varying degrees of accuracy. Capturing necessary (but expensive) inefficiency costs associated with time away from the clinic for military unique obligations such as physical fitness training and other training exercises is even more difficult. The effects of having a military medical presence regardless of level of utilization, a dispersion factor, must also be accounted for and explained as well as support to other forward deployed locations from a base in CONUS.

The Medical Readiness Costing Model workgroup will be guided by the Resource Management Steering Committee under the purview of the MHS Resource Management Breakthrough Group. The strategy for developing the readiness cost is to:

1. Identify a triservice representative who can address resourcing, manpower, training, health services delivery and field operations functions within the MHS
2. Identify standard terms and conditions for identifying and classifying military unique medical readiness costs
3. Identify a cost method and existing sources of costs (for all three Services) that are comparable and uniform in definition and application
4. Characterize costs as being in support of the total active force, for medical readiness of medical personnel, or for sustainment and training of medical personnel
5. Develop both a fully burdened and incremental cost for MHS provided services.

This effort will culminate in being able to defend both our cost of medical readiness and infer a true cost for peacetime health service delivery.

# MHS Optimization Plan

## February 1999 Interim Report

### Triservice Enrollment Model

#### CHARTER

Develop a MHS enrollment model which will establish standards for:

- ⌚ Primary care, specialty care, and operational product lines, provide
  - ⌚ Number of enrolled patients
  - ⌚ Number of direct support staff needed to maximize provider effectiveness
  - ⌚ Number of administrative/management staff needed for optimal efficiency
- ⌚ Consider all provider categories (physician and physician extenders as well as other independent providers)
- ⌚ Consider what local factors could increase or decrease projected enrollment ratios
- ⌚ Examine current total staffing and levels of efficiency

Collect data on the number of available personnel based on readiness requirements as well as current staffing per MTF for each Service. (These should be actual personnel regardless of their present job description - i.e.: determine the number of family practice physicians in an MTF regardless of whether they perform patient care.) Use existing MHS data bases to determine users in the catchment areas. Use civilian benchmarks and previous military studies to determine the number of providers and support staff needed for most efficient execution of operations for the above enrollment standards. Once data on number of patients and personnel are determined, use data from Readiness Costing model to determine readiness factors in developing the enrollee/provider ratios.

Please present your findings to the Deputies via the MHS Reengineering Coordination Team by 1 March 1999.

Reengineering will involve the appropriate resourcing and staffing of DOD facilities. A major part of that resourcing is personnel, specifically providers. Personnel allocations are less amenable to rapid change because of PCS and end strength constraints. Thus, allocations have much longer term implications and need to be viewed from a larger system-wide perspective. Poor allocation of providers among facilities will result in some areas that are under-served with reduced access, low satisfaction and potentially high bills for purchased services. Conversely, those areas rich in providers may be inefficient with high internal costs. Similarly, poor allocation of end strength among specialties may result in poor access to some specialty services and under-utilization of others. Prior to TRICARE, efforts to allocate manpower resources were hampered by our inability to define precisely for which population a facility was responsible. All services were provided on a "space available" basis and, as long as patients filled the appointment logs, facilities could "earn" their providers. TRICARE Prime, with its emphasis on managed care and its actual enrollment of beneficiaries, provides us with an opportunity to more precisely allocate this strategic resource of providers.

---

A key distinction of managed care for TRICARE Prime is the introduction of Primary Care Managers (PCMs). PCMs become the focal point of an enrollee's interaction with the health system. The PCM not only treats patients for routine illnesses and injuries but also serves as the referral point for specialty services and is responsible for preventive services and the health promotion of the enrollee. One of the basic constraints in determining the capacity of the MHS is the matching of enrollees with PCMs. Several studies have attempted to measure the appropriate ratio of PCMs to enrolled populations. Some have estimated panel sizes of 1,300 while others have exceeded 2,000.

***...provide a tool with which MTFs can model beneficiary enrollment under differing scenarios, compare that capacity with current enrollment figures and to current user estimates, and examine the geographical and specialty distribution of providers.***

Our current effort will provide a tool with which MTFs can model beneficiary enrollment under differing scenarios, compare that capacity with current enrollment figures and to current user estimates, and examine the geographical and specialty distribution of providers. It will begin with Primary Care Managers. Family Practice, General Medicine, General Pediatrics, General Internal Medicine physicians as well as Physician Assistants and Family Practice Nurse Practitioners will be considered PCMs in a practice panel model. (Flight Surgeons and other physicians assigned to line units will be considered in an operational product line analysis.) Using authorization numbers for these specialties by facility and applying panel sizes of 1,300 to 1,900, the enrollment capacity of each facility can be accurately estimated.

This enrollment capacity will then be compared to the number of enrollees currently served by the facility with an allowance for those bases with significant student/trainee populations that are not "enrolled" there because they are on temporary duty. The remaining (unused) capacity will be compared to estimates of space available users, i.e. potential enrollees. It will consider both Medicare eligible beneficiaries who currently do not have an opportunity to enroll (except at subvention sites) as well as those users who currently are opting to remain with TRICARE Standard.

Another excursion of the model will examine the effects of using a risk adjustment (equivalent lives based on age and gender adjustments), modified for population disease severity. Catchment area population epidemiological data can be applied to normative workload projections to yield prospective demand estimations. The demand estimations will predict the epidemiology of disease that a given population will produce and to which the health services delivery system will be expected to respond. This will form the basis for the make/buy decisions for obtaining necessary services.

***Catchment area population epidemiological data can be applied to normative workload projections to yield prospective demand estimations. The demand estimations will predict the epidemiology of disease that a given population will produce and to which the health services delivery system will be expected to respond.***

This modeling tool can then be used to examine

- ⌚ The equitable distribution PCM allocations across the MHS
- ⌚ The enrollment capacity (supply) and enrollment potential (demand) at specific locations
- ⌚ The effects of the distribution of PCMs on other variables such as access and referral patterns

Another tool will be developed for examining specialty mixes. Starting with enrolled populations by location, specialty ratios (taken from civilian benchmarks) will be applied to those populations to determine the number of specialists the population could support. If sufficient demand for a specialty

---

cannot be justified, then no specialist should be assigned to that facility. Summed over all facilities, this model will be used to examine the distribution of specialties both across facilities and among specialties. Potentially, the model could also support cross service provider and staff utilization strategies. Further analysis would start with differing scenarios of user populations to account for continued “space available” services.

Once the primary care, specialty care, and operational support models are developed, they will be used for programming decisions in the FY2002-2007 POM to best match enrolled populations to distribution of personnel.

**Status:** The **Capacity Planning Workgroup** has obtained authorization files by facility and specialty, enrollees by site, and civilian norms and has requested average student loads and equivalent lives have been requested. We are developing and fine tuning models for review.

# MHS Optimization Plan

## February 1999 Interim Report

### Population Health Improvement

#### CHARTER

Formulate a plan and develop a model designed to fully optimize clinical outcomes across the MHS. Your plan should include, but is not limited to, the following two major categories:

##### 1. Utilization Management

Develop a strategy on how to OPERATIONALIZE the DOD UM plan that includes the following elements:

- |                                  |                                |
|----------------------------------|--------------------------------|
| ⌚ Patient and provider education | ⌚ Case management              |
| ⌚ Health promotion/prevention    | ⌚ Clinical pathways/guidelines |
| ⌚ Primary care management        | ⌚ Disease management           |
| ⌚ Demand management              | ⌚ Discharge planning           |
| ⌚ Referral management            | ⌚ Utilization review           |

##### 2. Practice Guidelines

- ⌚ Develop or find a tool that will assist MTFs/Lead Agents in selecting those guidelines, clinical pathways, and disease management strategies that are associated with high cost, high risk, high volume and/or most significant operational impact and will accomplish a good return on investment (clinical or monetary). Recommend 12-18 practice guidelines that would be common to like MTFs and deploy them using a consistent deployment strategy. Finally, recommend appropriate metrics and a structure for updating the process as significant changes occur.
- ⌚ Determine where (military or commercial) successful guidelines, pathways, and disease management strategies have been successfully deployed, MEASURED and SUSTAINED and where they have failed. From this benchmarking determine best practice and develop a specific guide such as “How To Implement and SUSTAIN and MEASURE Practice Guidelines” for use by MTFs and Lead Agents.

Modify the UM plan as necessary. Be as specific as possible as to what resources will be needed and what structure and metrics must be in place for successful implementation.

The primary goal of the MHS is to optimize the health of all our beneficiaries: active duty, retired and family members. Population health improvement of our active duty members is the cornerstone of force health protection. Moving to population health as our primary objective represents a major

***Population health improvement of our active duty members is the cornerstone of force health protection.***

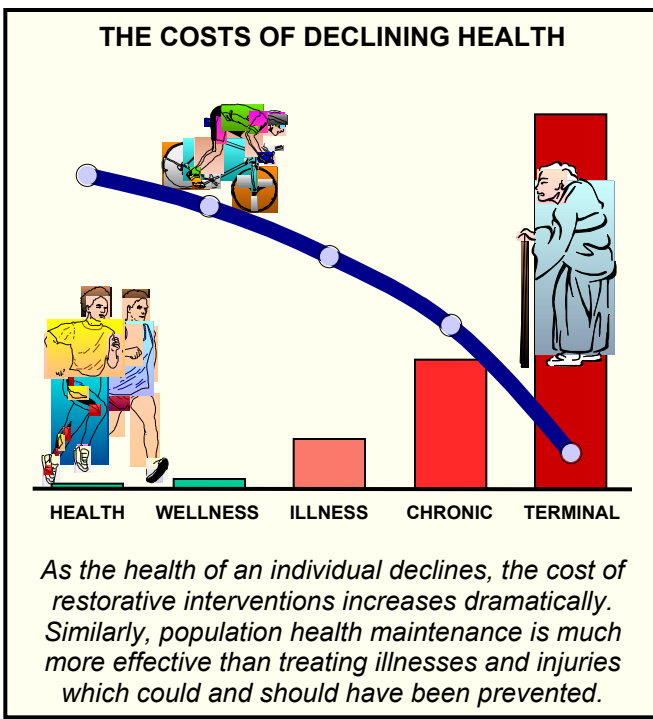
paradigm shift from the traditional “medical model” which focuses solely on the clinical care of patients presenting to the provider’s office. By focusing on the health, rather than “medical care” of our beneficiaries, the MHS will optimize the use of all resources through adoption of best population-based and clinical practices. Core components of the plan must include utilization management and



practice guidelines as outlined in the Charter. However, population health improvement using numerous strategies is much broader than these two categories commonly used in managed care. The MHS Population Health Improvement plan will specify MHS-wide policies, practices, tools, metrics and incentives which are necessary to systematically optimize the health and performance of our beneficiaries, building upon, but not restricted to, best civilian managed care concepts and practices.

As the figure at right illustrates, declining health demands increasingly expensive restorative interventions. Primarily maintaining the health of our population is not only in our beneficiaries' best interest but also requires the least dedication of resources. Immunizations, for example, cost pennies but prevent devastating and costly illnesses. We must extrapolate these successes to a much wider range of illnesses and injuries for which procedures, medications, and other treatment modalities are poor alternatives to primary prevention and early diagnosis.

This will require a refocusing of our practice of delivering health services – from emphasis on individual treatments to improvement of the population's health. **Performance metrics must be used which emphasize and reward population-based health improvement.**



## Critical Success Factors

The critical success factors for the Population Health Improvement plan are many. Chief among them are the following six:

**1. Standardized and accurate enrollment processes must be available to responsible health service providers. The DEERS and DEERS-CHCS interface must be flawless so patients can be accurately enrolled to providers who, only then, will be able to manage the health of their enrolled patients. For utilization management and population health improvement to be successful, immediate steps must be taken to ensure the accuracy of enrollment and other population data.**

***Accurate enrollment and integrated information systems are essential first steps for any Population Health Improvement or Utilization Management initiatives.***

2. Standardized health assessment must be available with rapid feedback to providers. The Health Enrollment Assessment Review (HEAR) must be refined, automated, and rapidly transmitted to a computerized patient record or incorporated into existing data systems. Providers must receive timely individual and aggregate (by panel) reports to manage the health of enrolled patients.

3. We must use standardized performance measures based (where appropriate) on civilian performance benchmarks. Clinical outcome, satisfaction, cost-efficiency, and readiness-related standardized metrics must be automated, available and visible across the enterprise.



---

4. Standardized tools must be available to facilitate use of best population-based and clinical practices. Comprehensive marketing and education programs, self-care programs (health care information lines, web-based approaches and books, educational interventions, *etc.*), disease and demand management practices and tools (clinical practice guidelines, clinical pathways, referral guidelines, *etc.*) must be refined, developed and implemented in a standardized fashion.

5. We must offer standardized incentives for both providers and patients which are directly linked to performance measures. Providers, staff and commanders require timely feedback on their performance measures for reflecting the effectiveness, efficiency and customer satisfaction of the health services provided to their beneficiaries. Clear incentives should be created to encourage patients to proactively improve their health in partnership with their providers.

**6. The Computerized Patient Record and other Integrated IM/IT Tools are essential! While a few aspects of a the Population Health Improvement plan can be initiated using existing data systems (which the workgroup will define and recommend implementation near term), full achievement of both the promise and resource efficiencies of MHS reengineering is dependent upon full implementation of a computerized patient record. To ensure population health improvement requirements are accurately reflected in any integrated information system, this workgroup must be responsible for providing functional requirements for both near term solutions and the computerized patient record.**

**The Computerized Patient Record and other Integrated IM/IT Tools are essential!**

Many of the barriers to achieving these critical success factors are known and are being systematically addressed by the Population Health Improvement workgroup. Many of the tools and practices have been developed but require MHS-wide implementation. The Population Health Improvement plan will identify existing barriers, develop implementation deliverables and timelines and specify resourcing offsets and needs both near term and for comprehensive reengineering in the FY2002-2007 POM submission.

# **MHS Optimization Plan**

## **February 1999 Interim Report**

### **Triservice Workload Model**

#### **CHARTER**

Propose a method of standardizing the process for collecting and analyzing data and converting data to information on which business decisions can be made. Specifically, you should:

- ⌚ Standardize enterprise-wide business rules, policies, and procedures to ensure data accuracy, timeliness, and validity for MTFs.
- ⌚ Identify data sources, data integrity issues, and data standards
- ⌚ Develop corrective actions necessary to obtain accurate workload data.
- ⌚ Determine an enterprise-wide, standard internal management control program that will ensure data accuracy and standardization procedures for the workload reporting program.
- ⌚ Identify business changes required to ensure accurate workload data.
- ⌚ Develop an implementation plan with deliverables, timelines, and responsible persons.

Please present your plan and timelines to the Deputies via the MHS Reengineering Coordinating Team by 1 March 1999.

The Military Health System (MHS) optimization program is dependent on our ability to provide comparisons of costs throughout all DOD facilities. Measuring performance and cost effectiveness within the MHS, comparing alternatives, and making informed management decisions is predicated on standardized, timely, consistent and accurate information. As the MHS moves toward standard resourcing and measurement models that enable us to benchmark and resource our healthcare system, it becomes increasingly important that we put increased effort into data quality management and oversight.

MEPRS (Medical Expense and Performance Reporting System) is the MHS' current cost accounting system for reporting expenses, manpower, and workload data by DOD fixed medical and dental treatment facilities. The purpose of the MEPRS Management Improvement group (MMIG) is to develop and implement standard business rules across the Military Health system (MHS) for calculating, collecting and reporting MEPRS data.

The MMIG began work on this project in October 1998 and completed the first phase in January 1999. Phase 1 identified areas for standardization, inclusion of costs not currently captured, reconciliation processes and compliance metrics to increase accuracy, and education & training requirements. The consensus reached by the MMIG was briefed to the Resource Management Steering Committee for their review and approval. In phase 2 of the project, the MMIG will develop detailed implementation plans and policy guidance for implementing these improvement initiatives.

---

The MMIG developed high level guidance to standardize capture and reporting for depreciation, labor, overhead support, and visits. The MMIG also reached consensus on inclusion of expenses not currently captured in MEPRS. These expenses include resource sharing assets, gifts and donations, other centrally managed funds, and other appropriations.

To ensure accuracy of MEPRS data, the workgroup identified a requirement to establish reconciliation processes to validate and explain data coming from source systems and the inputs and outputs from MEPRS. Reconciliation will be done and reported for all inputs into MEPRS, i.e., financial data from service financial systems, workload data from CHCS (Composite Health Care System), and manpower data from templates or timesheets. Compliance metrics were also developed to ensure and enforce policies and guidance for timely submission, workload, labor and expense data.

Finally, the MMIG developed an education & training program so improvement initiatives and procedures are communicated to responsible parties to ensure successful implementation.

**Status:** Phase 1 decisions were briefed to Resource Management Steering Committee on January 21, 1999. Phase 2 immediately followed. Implementation of improvement initiatives immediately focused on “low hanging fruit.” Other initiatives will be assessed for system change requests and determination of costs needed to implement. The goal is to begin implementation of all initiatives by June 1999.

# MHS Optimization Plan

## February 1999 Interim Report

### Triservice Resourcing Model

#### CHARTER

Provide the MHS with a standardized, universally accepted, top line model to consistently reflect policy changes affecting DHP resources by component. This model must have the capability to project MHS resource requirements based on varying strategic plan and Service line support scenarios. This model will also support measurement of the component's effectiveness in meeting performance metrics.

Suggested model elements include:

- ⌚ Encompass the entire time spectrum of the PPBS cycle
  - ⌚ Reflects total DHP resource picture for the entire FYDP
  - ⌚ Reflects the resource impacts of MHS policy decisions
  - ⌚ Reflects impacts of DHP execution allotments by component, including DHP reserves
  - ⌚ Incorporate components of existing models, including managed care, capitation modeling, and enrollment based capitation scorecards (for retrospective cost and performance analysis and prospective decision making)
  - ⌚ Provide full asset visibility and inter-Service comparability of all components
  - ⌚ All components' data are comparable and uniform in definition and application
  - ⌚ Incorporates performance metrics to gauge planned and actual resource consumption
- Incorporates performance metrics consistent with the DOD performance contract between ASD(HA) and the Defense Management Council (*"By the end of FY98, develop a metric for fully loaded per capita health care cost per active duty member..."*)

Inherent in developing a fully integrated health services delivery system for the MHS is the requirement for appropriately resourcing the Services and their MTFs in a stable business-like environment that ensures appropriate incentives to support the overarching strategy of optimizing MTF capability – focused on providing services to a primarily enrolled population. Resourcing is the enabler and driving force that supports MTF infrastructure, military personnel assignment and performance appraisals, use of civilians and contract support as well as day-to-day operations and maintenance expenditures for consumable supplies, such as pharmaceuticals. The optimized MTF is resourced to best take advantage of all the factors of production and be a cost effective provider of health services. In the global sense, appropriately capitating MTFs for improving their populations' health maintenance is the resourcing imperative. How each of the Services and TMA conduct their individual business activities, with inherently different command structures and financial reporting systems, provides the central oversight challenge to equitably distribute resources and monitor performance.

The RM Breakthrough Group, chaired by the DASD for Health Budgets and Financial Policy, consists of the Service Senior Resource Managers and the Director of Resource Management, TMA. This workgroup constituted in April 97 has as its focus four objectives:

- 
1. Create an HA policy memorandum for the DHP PPBES process, in consideration of the new HA/TMA relationship and the evolving Service expectations.
  2. Establish a structure for decision-making.
  3. Establish/document a uniform DOD/Component-level decision process to increase effectiveness of the DHP resource decisions.
  4. Provide a uniform system to support a structured decision process at the DHP/Component level.

The workgroup's primary focus has been on objective 3. The owner of this objective is the Director or Resource Management, TMA. The task as stated is to: develop an integrated POM/Budget and allocation model (PPBES) based on a capitation method. Recent TMA/SGs' efforts to integrate the processes, with consideration of Comptroller, RAND, DPAE and other external agencies emphasize the need for an incentive based allocation model. This requirement is also linked to MHS Reengineering Initiative #28 to improve MHS resourcing. Thus far, the main focus has been on developing a full asset visibility model. The identified objectives from MHS Reengineering Coordination Team are already embedded to a large degree in objective 3; the added perspective focused on allocation and incentives to support enrollment can be addressed by the breakthrough group.

The Resource Management Steering Group, the current structure for addressing Service and TMA resource issues and requirements as well as proposed policy and program initiatives, will review the progress on meeting the MHS Reengineering objectives. The timeline for systematic changes reflected in the Program/Budget cycle is the FY2002-FY2007 POM. Some of the resourcing, allocation, and measurement tools can be employed in concert with other components of facility optimization, once the Most Effective Organization (MEO) facility model is determined. Capitation along with other Service specific policies could incentivize MTFs to share or swap production factors to optimize MTF capacity and increase MTF enrollment.

# MHS Optimization Plan

## February 1999 Interim Report

### Triservice Metrics

#### CHARTER

Provide the MHS with a standardized and meaningful performance measurement system. This system will provide useful feedback for all levels (*i.e.*, MTF, Lead Agent, TMA and Health Affairs) by using existing data bases, without undue hindrance on patient care and with maximum use of automation tools. Opinions and input from leaders at all MHS levels will be used to evaluation usefulness of metrics and validate the system's role in supporting quality improvement. This effort will capitalize on performance tools developed by HA, TMA and the Services by incorporating the most favorable aspects of each.

The final product will be a performance measuring system which will assess force health protection and cost, quality, access, and satisfaction of our health services.

The MHS is replete with metrics covering a wide range of uncoordinated indicators of varying usefulness. Moreover, the MHS continues to struggle with disparate performance measurement systems developed by HA, TMA and the Services. As the MHS continues to progress in its efforts to achieve system optimization, it is crucial that there is a consistent, universally accepted performance measurement system which can effectively provide feedback and act as the "gauge" for desired outcomes.

The Triservice Metrics Workgroup will analyze various products currently available and develop a single, standardized set of "core" metrics that can be used to assess the effectiveness of MTF optimization. Their efforts will incorporate the principles of utilization/quality management into the MHS. Data will be drawn from existing systems and proliferation of performance information will take full advantage of web technology.

This metrics standardization effort will examine a broad spectrum of indicators to include technical quality, service quality and system quality, to select measures that can be used to improve performance. Measures will focus on those that can be accomplished in the near future.

Finally, there needs to be an ongoing evaluation of selected measures with continual refinement to keep pace with clinical practice parameters as well as influence from outside agencies such as JCAHO and NCQA.

# MHS Optimization Plan

## February 1999 Interim Report

### Most Effective Organization

#### OBJECTIVE

Determine the requirements of a “most effective” health services delivery system using best business practices and analyze how to best fill the gap to maximize resource efficiency in the Military Health System.

**The MHS must have an energized strategic planning process that articulates the end state vision, builds plans and programs directly tied to the vision, allocates resources directly tied to desired outcomes, and measures progress toward achieving its goals and objectives.** Organizational structures and processes must be continually reviewed and improved to ensure rapid progress is made toward achieving the MHS end state vision. MHS enterprise-level decisions must

***Employ MHS resources in the most effective manner, using ‘best clinical and business practices’ gleaned from the most successful benchmark organizations.***

first be defined, then facilitated in areas that cut across organizational lines to achieve maximal efficiencies. The “most effective organization” will facilitate smooth business relationships between MTF commanders, Lead Agents, and Managed Care Support Contractors.

Key to building a “most effective organization” and accomplishing other goals is our ability to track individual and population-based clinical data, system and individual performance, and other quality indicators. **Data integrity and a computerized patient record are essential** for progress. We must have the capability to gather meaningful data to be converted to information on which we can make business decisions.

We anticipate continual improvement and refinement of our policies, practices, and processes and incorporation of evolving technology will be required for the MHS to become a “most effective” organization.

**The MHS must be effectively organized to have the following capabilities:**

- ⌚ Responsiveness to readiness mission in the spectrum of conflict as well Operations Other Than War (OOTW).
- ⌚ Focus on customer needs and expectations about access to health services and information about health services – including enrollment, health benefits, and claims assistance.
- ⌚ Maintenance of world class quality using applicable accrediting agencies from the civilian sector as well as best clinical practices spanning health education and promotion, primary and specialty care management, the full range of utilization management, continuing medical education, and evidence-based medical practice.



- 
- ⌚ Best business practices in administration of health service delivery using state of the art information technology and standardized business cases analysis tools.
  - ⌚ Population health management with enrollees as full partners in their health decisions
  - ⌚ Health services delivery platform commanders incentivized with clear and concise performance milestones.

***Vision, strategic planning, implementation plans, resourcing, performance evaluation, feedback and incentives must all be intricately linked through organizational structures and processes to ensure the MHS becomes a Most Effective Organization.***

**Key components of the MHS most effective organization must include:**

- ⌚ Strategic planning specifically tied to the MHS end state vision.
- ⌚ Programming, budgeting and assessment of performance at all levels specifically tied to strategic plan.
- ⌚ Linkage of accountability with clear definition of responsibilities for all organizational components.
- ⌚ Develop organizational structures, responsibilities and processes to ensure enterprise-wide decision-making and minimal cycle times for MHS-wide implementation of plans, policies, and tools.
- ⌚ Standardized performance measures with timely feedback to all levels of the enterprise for rapid quality improvement through dissemination of best practices.
- ⌚ Streamlined oversight and management of information systems ensuring alignment with MHS strategic plan and end state vision.
- ⌚ Ensure the MHS is a “learning organization” which embraces change and ongoing incorporation of innovative best practices.

***In some cases, Service-specific readiness staffing requirements will need to be supplemented with additional resources to be a “most effective organization. After we identify these needs, we must perform make/buy decisions (business case analyses) and find ways to assemble the staffing necessary to allow our system to be fiscally efficient.***

# MHS Optimization Plan

## February 1999 Interim Report

### Timeline

